MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10700

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany County

City or town: Frostburg Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Miner's Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart Mines

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Linda Katherine Allan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 29 1947

8. AGE: Years	Months	Days	If less than one day
	2	1	..... hrs. ..... min.

9. Birthplace: Miners Hospital, Frostburg, Md.

(Town, ... and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Francis Joseph Allan

13. Birthplace: Eckhart Md.

MOTHER

14. Maiden name: Mary Frances Brooks

15. Birthplace: Leaksville, N. Carolina

16. Informant: Mrs. Francis Allan

Address: Eckhart Mines, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/47 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg Maryland

18. Funeral director: Jacob Hafer

Address: Frostburg Maryland

19. 12-31 1947 Mrs. Mabel N. Rice

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-30 1947 at 12:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27 1947 to 12-30 1947 and that I last saw h[illegible] alive on 12-29 1947

Immediate cause of death	DURATION
Bronchial-pneumonia	2 d.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank T. Harrat M.D. M.D. or other

Address 59 East Main St., Frostburg Date signed 12-31-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Within corporate limits

Trevaskis-Jr.

10701

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 626 Baltimore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME John Wesley Anderson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jemimah E. Hamilton

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Nov 15 1874

8. AGE:

Years	Months	Days	If less than one day
73	1	1	...hrs. ...min.

9. Birthplace: Zihlman, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Miner - Retired

11. Industry or business: Coal Mines

FATHER

12. Name: Edward Anderson

13. Birthplace: Carlos, Md.

MOTHER

14. Maiden name: Sarah Crowe

15. Birthplace: Md.

16. Informant: Mrs. Martha Stevens

Address: 169 N. Center St. Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18, 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Dec 18 1947 (Date rec'd by registrar) W. L. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945, to Dec 1947

and that I last saw him alive on December 15 1947

Immediate cause of death	DURATION
Myocarditis	2 yrs
Due to: Arteriosclerosis	
Due to:	
Other conditions: Bronchial asthma	50 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results: not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: R. Whevaskis Jr. M.D. M. D. or other

Address: Cumberland Md Date signed: Dec 17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10703

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred: 703 Race St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 703 Race St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter Grafton Apple

3.(b) Social Security Number 705-09-4843

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ennie Harris

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) April 28 1879

8. AGE:

Years	Months	Days	If less than one day
68	7	20	...hrs. ...min.

9. Birthplace Orleans Ind.
(Town, county, and state)

10. Usual occupation Crossing Watchman (Ry)

11. Industry or business Retired 7 yrs

FATHER 12. Name George Apple

13. Birthplace Orleans Ind

MOTHER 14. Maiden name Harriet Ashbette

15. Birthplace Ind

16. Informant Norris Apple

Address Cumberland Ind

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-20-47 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland

19. 12-19 19 47 (Date rec'd by registrar) W. R. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 19 47 at 7 30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 13 19 47 to Dec 18 19 47 and that I last saw h... alive on Dec 18 19 47

Immediate cause of death	DURATION
Myocardial Insufficiency	1 yr
Due to Arterio Sclerosis	4 yrs approx
Due to	
Other conditions Diabetes Mellitus	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David T Lee M. D. or other

Address 404 Decatur St Date signed 12-19-47

Within corporate limits: Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124b

10703

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? SEVEN DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town ~~CUMBERLAND~~ Oldtown
(If outside city or town limits, write RURAL and give nearest town)
Street No. ~~OLDTOWN~~
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
GEORGE A. ATHEY

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife PEARL MATTHEWS 6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 17, 1871

8. AGE: Years	Months	Days	If less than one day
76	0	11	...hrs. ...min.

9. Birthplace MARYLAND.
(Town, county, and state)
10. Usual occupation FARMER
11. Industry or business

FATHER
12. Name UPTOM ATHEY
13. Birthplace MARYLAND

MOTHER
14. Maiden name Sarah E. (?)
15. Birthplace MARYLAND.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAMD, MARULAND.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30, 1947 (month) (day) (year)
Cemetery or crematory Davis Memorial Cemetery
Location Cumberland, Md.
18. Funeral director John A. Hafer
Address Cumberland, Md.

19. Dec. 30 1947 (Date rec'd by registrar) C. R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 28 1947 at 12:13 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Dec 1947 to 28 Dec 1947 and that I last saw him alive on 28 Dec 1947

Immediate cause of death	DURATION
Cardiac Failure	
Due to Aortic Insufficiency	
Due to	
Other conditions Carcinoma of Liver	
Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE L. D. Lantzman M.D.
M. D. or other
Address 125 Center St. Date signed 29 Dec 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 2 10704

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 years

Hospital, institution, or street address where death occurred:
363 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 363 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Kohl Barnecord

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widow

6.(b) Name of husband or wife David Barnecord

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 21, 1862

8. AGE: Years	Months	Days	If less than one day
85	0	4	..... hrs. ..... min.

9. Birthplace Cumberland-Allegany-Maryland
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business Own business

FATHER 12. Name Henry Kohl

13. Birthplace Germany

MOTHER 14. Maiden name Catherine Smith

15. Birthplace Germany

16. Informant Mrs. Newton Parrish

Address 363 Bedford St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 27, 1947 (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Dec. 27 1947 (Date rec'd by registrar) Walter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1947, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Dec 25 1947, and that I last saw h.. alive on Dec 24 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 week
2 Side Hemiplegia	
Due to: Arteriosclerosis	2 mos.
Due to: Senility	
Other conditions: Hypertension	
(Include pregnancy within 3 months of death)	

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Allen S. Warren M. D. or other

Address Cumberland Md. Date signed Dec 26 47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10705

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs.

Hospital, institution, or street address where death occurred: 248 N. Center St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 248 N. Center St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Gladys Minnie Barnett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 30 1939

8. AGE: Years 8 | Months | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Ralph M Barnett

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Mary E Friend

MOTHER — 15. Birthplace: Md.

16. Informant: Ralph M. Barnett

Address: 248 N. Center Street.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Fayette St.

18. Funeral director: Louis Stein & Son

Address: Cumberland

19. Dec 26 1947 (Date rec'd by registrar) Hunter R Grant M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1947 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1947, to Dec 25 1947 and that I last saw h.. alive on Dec 25 1947.

Immediate cause of death	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Hunter R Grant M.D. or other

Address 12/26/47 Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

10796

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: rear) 839 Shriver Ave. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 10 years

Hospital, institution, or street address where death occurred: rear 839 Shriver Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: rear) 839 Shriver Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Albert Frank Bechtel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	~~married~~ Single

6.(b) Name of husband or wife: Not married

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Nov 7, 1884

8. AGE: Years	Months	Days	If less than one day
63	1	22	...hrs. ...min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Itinerant Worker

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs Paul Goldsworthy

Address: 839 Howard Ave, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31. 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md

18. Funeral director: Ellsworth G Beal

Address: Westernport, Md.

19. Dec. 30 1947 (Date rec'd by registrar) W.R. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 1947 at about 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on Dec. 29 1947

Immediate cause of death	DURATION
cerebral hemorrhage	at once
Due to: shot himself with a 22 caliber rifle	
Due to:	
Other conditions: failing health, about 1 year. chronic myocarditis & bronchial asthma (Include pregnancy within 3 months of death)	

Major findings of operation: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: 12-29-47

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, Industry, public place (where?): home

Means of injury: Shot himself Injured at work? 12-29-47

Deputy Medical Examiner

23. SIGNATURE: H. V. Deming M.D. H.V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 12-29-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10707

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Months

Hospital, institution, or street address where death occurred: 114 Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 114 Potomac St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Diana Carol Beeman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife: Child

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 16- 1947

8. AGE: Years	Months	Days	If less than one day
0	6	14	hrs. min.

9. Birthplace: Cumberland Md., Allegany Co. (Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER — 12. Name: Everett Beeman

13. Birthplace: Ridgeley, W. Va.

MOTHER — 14. Maiden name: Julia Beal

15. Birthplace: Cumberland, Md.

16. Informant: Everett Beeman

Address: 114 Potomac St, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 1, 1948 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Meyersdale, Penna

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 31 1947 (Date rec'd by registrar) W. R. Bantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1947 at about 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on Dead Dec. 30 1947

Immediate cause of death	DURATION
Bronchiopneumonia & acute	about
trachea brochitis	2 days
Due to	
Due to	
Other conditions: Expulsive stomach contents	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 12-30-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10708

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D.#3 Bowmans Addition
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Calvin Wesley Berry

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 16, 1947

8. AGE:

Years	Months	Days	If less than one day
	6	12	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Benjamin Smith
13. Birthplace: Petersburg, W. Va.

MOTHER
14. Maiden name: Adeline Crowe
15. Birthplace: Flintstone, Md.

16. Informant: Mrs. Adeline Crowe
Address: R.D.#3 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30 1947 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Dec. 30 1947 (Date rec'd by registrar) Wm. A. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28, 1947, at 2:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1947 to Dec 28 1947 and that I last saw h... alive on Dec 28 1947

Immediate cause of death	DURATION
Lobar Pneumonia	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results: Lobar Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harold G. Wareham M.D.

Address: 122 Bedford St M. D. or other

Date signed: 12/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a

10709

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 540 Fairview Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edith Biller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Preston Biller

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): December 25, 1887

8. AGE: Years	Months	Days	If less than one day
60	11	24	...hrs. ...min.

9. Birthplace: Summit Point Jefferson Co, W. Va.
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: George B. Wyandaham
13. Birthplace: Berryville, Va.

MOTHER
14. Maiden name: Mary F. Sinclair
15. Birthplace: Summit Point, W. Va.

16. Informant: Preston Biller

Address: 540 Fairview Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/21/47 (month) (day) (year)

Cemetery or crematory: Hill Crest Burial Park

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec 20 19... (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1947 at 3-10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to 12/19 1947

and that I last saw h[illegible] alive on 12/18/47 ...19...

Immediate cause of death	DURATION
Bronchopneumonia	
Due to:	
Due to:	
Other conditions: chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: Ovst of ovarian hernia

Date of op. 12/15/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: John H. Rowen M D
M. D. or other

Address: [illegible] Date signed 12/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10710

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL Hospital
How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town WESTERNPORT, MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 105 MAIN ST.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME DEWEY BRASHEAR,

3.(b) Social Security Number 216-07-8453

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife LENA JACKSON BRASHEAR
6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) NOV. 19, 1897

8. AGE: Years	Months	Days	If less than one day
50	0	19	hrs. min.

9. Birthplace Westernport, Allegany County, Maryland
(Town, county, and state)
10. Usual occupation Mechanic
11. Industry or business Garage

FATHER
12. Name EDEN BRASHEAR
13. Birthplace Maryland

MOTHER
14. Maiden name LA VAUDA DUCKWORTH
15. Birthplace ~~MD~~ Westernport, Maryland

16. Informant Hospital Records
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 11, 1947 (month) (day) (year)
Cemetery or crematory Rose Cemetery
Location Westernport, Md.
18. Funeral director Edmonds & Bond
Address Westernport, Md.

19. Dec. 10 1947 (Date rec'd by registrar) W. R. Hawtz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 8 1947, at 2:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 26 1947 to Dec 8 1947 and that I last saw h.. alive on Dec 8 1947

	DURATION
Immediate cause of death Chronic Nephritis	
Due to Hypertension	
Due to (Uremia)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 12/10/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

DR. SCHINDLER
DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10711

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 hrs. 7 Min.
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 8 Hrs. 7 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County ~~ALLEGANY~~ Bedford
City or town ~~R.F.D. 2 FLINTSTONE~~ Beans Cove.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BRIDGES, MILDRED MISS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 4, 1934

8. AGE: Years	Months	Days	If less than one day
13	10	20	hrs. min.

9. Birthplace PENNA. Bedford Co.
(Town, county, and state)
10. Usual occupation STUDENT
11. Industry or business

FATHER
12. Name CHARLES BRIDGES
13. Birthplace PENNA. Bedford Co.

MOTHER
14. Maiden name ANNA ROBINETTE
15. Birthplace PENNA, Cheneysville

16. Informant Charles Bridges
Address RD #2 Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27, 1947 (month) (day) (year)
Cemetery or crematory Beans Cove Methodist Cem
Location Beans Cove, Bedford Co., Penna
18. Funeral director John F. Naftz
Address Cumberland, Md

19. Dec 27 1947 (Date rec'd by registrar) Hunter A. Trout, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 24 1947, at 11:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24 1947 to Dec. 24 1947
and that I last saw h alive on Dec. 24 1947

Immediate cause of death	DURATION
Diphtheria	5-7 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M.D. M. D. or other
Address 41 Fremont Date signed Dec 25, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

S A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10712

Reg. Diat. No. 9

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany

City or town: R.F.D. Frostburg, Md. (Wright's Crossing)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: R.F.D. Frostburg — Wright's Crossing

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward Stanley Cafel

3. (b) Social Security Number 214-07-6249

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Edna Ruth Neilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 2 - 1913

8. AGE: Years	Months	Days	If less than one day
34	7	26	..... hrs. ..... min.

9. Birthplace: Loartown Md (Town, county, and state)

10. Usual occupation: Cabinet Case of Am.

11. Industry or business: Rayon

FATHER 12. Name: Ed. Cafel

FATHER 13. Birthplace: Frostburg Md

MOTHER 14. Maiden name: Bertha Loar

MOTHER 15. Birthplace: Vale Summit Md

16. Informant: Mrs. Edna Cafel

Address: R.F.D. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany Cemetery

Location: Frostburg Md

18. Funeral director: J. R. Durst

Address: Frostburg Md.

19. 12-31 1947 Mrs. Nancy V. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1947, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h/l/m alive Dec 28 1947

Immediate cause of death	DURATION at once
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. K. Deming M.D. M. D. or other

Address: Cumberland, Md. Date signed: 12-28-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

88a

·10713

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs 5 da.

Hospital, institution, or street address where death occurred:

Allegany Co. Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Altamont Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John A. Cavanaugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Ruth Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 6 1880

8. AGE:

Years	Months	Days	If less than one day
67	—	15	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Hotel Prop.

11. Industry or business Retired

FATHER 12. Name John C. Cavanaugh

13. Birthplace Ireland

MOTHER 14. Maiden name Anna Dwyer

15. Birthplace Ireland.

16. Informant Jos. Michael Cavanaugh

Address York Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23 47 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Dec 23 1947 Wm. Trautz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1947 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947 to Dec. 21 1947 and that I last saw him alive on Dec. 19 1947

Immediate cause of death	DURATION
Cerebral Vascular Accident	5 days
Due to	
Due to Generalized Arteriosclerosis	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other

Address 110 S. Centre St. Date signed 12-22-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

10714

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 6 months

Hospital, institution, or street address, where death occurred: Brunswick Hotel

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Brunwick Hotel
(If rural, give LOCATION)

2.(a) If veteran, name war World War 1

3.(a) FULL NAME George E. Chenowith

3.(b) Social Security Number 217-10-1359

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife Ida May Howarth

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1883

8. AGE: Years	Months	Days	If less than one day
64	2	7	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation stone & brick mason

11. Industry or business Contract work

FATHER 12. Name Banjamin Chenowith

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Mary L. Hughes

15. Birthplace Cumberland, Md.

16. Informant Mr. Charles Chenowith

Address 316 Holland St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29, 1947 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Dec 29 (Date rec'd by registrar) 1947 W.R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 19 47 at about 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on Dead Dec. 26 19 47

Immediate cause of death	DURATION
Uremia	?
Due to Chronic parenchymatous nephritis	several years
Due to	
Other conditions Chronic bronchial asthma also dropsy (Include pregnancy within 3 months of death)	several years

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md Date signed 12-26-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138 10715

Reg. Dist. No. 4

W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 yrs

Hospital, institution, or street address where death occurred:

376 Grand Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany.

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 376 Grand Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine Louise Clarke

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Philip H. Clarke

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1881

8. AGE: Years	Months	Days	If less than one day
66	2	26	..... hrs. ..... min.

9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER

12. Name Casper Rohman

13. Birthplace Md

MOTHER

14. Maiden name Matilda Ehrhar

15. Birthplace Md.

16. Informant Mrs. Jos. Hasselbarger

Address Cumberland

17. Burial (Burial, cremation, or removal? Which?) Date thereof Jan 2 '48 (month) (day) (year)

Cemetery or crematory St Peter & Paul's Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Dec. 31, 1947 (Date rec'd by registrar) W. K. Trapp M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1947 at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1947 to Dec. 30 1947

and that I last saw her alive on Dec. 29 1947

Immediate cause of death	DURATION
Myocarditis	6 mos
Due to Fatty Low Arteriosclerosis - Luetic	5
Due to Tuberculosis (Pulmonary)	2
Due to Diabetes mellitus	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay R. Lewis M.D.

M. D. or other

Address Cumberland Date signed 12/30/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10716

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 5 days.

Hospital, institution, or street address where death occurred: Allegany Hospital.

How long in hospital or institution? 4 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Penna. County Bedford

City or town Hyndman (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Jane Clites Baby Girl Clites - Twin #1

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe.	W.	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 28 1947

8. AGE: Years | Months | Days 5 4 | If less than one day hrs. min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Earl Clites

13. Birthplace Pa

MOTHER 14. Maiden name Doris Lepley

15. Birthplace Pa

16. Informant Earl Clites

Address Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 3 47 (month) (day) (year)

Cemetery or crematory Hyndman

Location Hyndman, Pa.

18. Funeral director H. A. Ziegler

Address Hyndman Pa.

19. Dec 3 1947 W R Bautz, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 / 1 1947, at 11.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 / 28 1947, to 12 / 1 1947

and that I last saw h.. alive on 12 / 1 1947

Immediate cause of death	DURATION
Pulmonary Atelectasis	Birth
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward Topper M.D. M. D. or other

Address Hyndman Pa. Date signed 12.3.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

Trevaskis, St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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10717

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

745 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 745 Fayette St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ann Collins

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Sanford W. Collins

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) January 22, 1884

8. AGE:	Years	Months	Days	If less than one day
	63	10	24	..... hrs. ..... min.

9. Birthplace Bedford Co., Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name David Meeks

13. Birthplace W. Va.

MOTHER 14. Maiden name Lucretia Sowers

15. Birthplace Artemas, Pa.

16. Informant Sanford W. Collins

Address 745 Fayette St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 19, 1947 (month) (day) (year)

Cemetery or crematory Rose Hill Mausoleum

Location Cumberland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Dec 18 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1947, to Dec 16 1947 and that I last saw h-ex- alive on Dec 12 1947

Immediate cause of death Cancer of face — DURATION 3 years

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. A. Trevaskis, M.D. M. D. or other

Address Cumberland, Md Date signed 12/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use typewriter if convenient. Physicians, please write the causes of death clearly and legibly. This certificate is especially important.

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

106a

10718

CERTIFICATE OF DEATH

Reg. Dist. No. 4

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

County: Allegany

City or town: rural) near Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:
Died in route to Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Rural) near Barrelsville Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Richard Lee Combs

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 22-1947

8. AGE: Years: 0 | Months: 3 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Harrison Jefferson Combs Sr.
13. Birthplace: Greenpoint Md.

MOTHER
14. Maiden name: Eleanor Bucklew
15. Birthplace: Cumberland Md.

16. Informant: Mrs. Eleanor B. Combs.
Address: R.F.D. Mt. Savage Road Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Dec 8 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 8, 1947 Wm. Lantz, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 4 19 47 at about 1 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on Dead Dec. 4 19 47

Immediate cause of death	DURATION
Acute tracheal bronchitis	a few hr
Due to Bronchial obstruction due to mucus plugs & atelectasis	
Due to of the lungs, septicemia & Adrenal hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming MD
M. D. or Other

Address: Cumberland Md. Date signed: 12-4-47

Within corporate limits

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10719

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 MONTHS 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County HAMPSHIRE

City or town GREENSPRING
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. BESSIE CRABTREE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife WILLIAM CRABTREE

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) MARCH 2, 1896

8. AGE: Years	Months	Days	If less than one day
51	9	22	hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name ARTHUR COOPER
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name MARIE HOOVER
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27 47 (month) (day) (year)

Cemetery or crematory Forest Glen Mem Cem.

Location Hampshire Co, W. Va.

18. Funeral director Louis Stein & Son

Address Cumberland

19. Dec 26 1947 (Date rec'd by registrar) Hunter A. Tantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 24, 1947 at 7:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Oct 1947 to 24 Dec 1947 and that I last saw her alive on 24 Dec 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis	
Due to Primary Carcinoma	
Due to Cervix	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fuller B Whitworth M. D. or other

Address 112 Bedford St Date signed 24 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits Rush Wms.

W

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10720

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred: 12 Euclid Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Euclid Place.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wm Francis Davis
3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Rebecca F. Proffitt
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): Oct 4, 1873

8. AGE: Years 74 Months 2 Days 7 If less than one day ... hrs. ... min.

9. Birthplace: Rush, Allegany Co, Md. (Town, county, and state)
10. Usual occupation: Tannery Worker
11. Industry or business: Union Tanning Co.
FATHER 12. Name: Isaac Davis
13. Birthplace: Unknown
MOTHER 14. Maiden name: Caroline Hite
15. Birthplace: Unknown
16. Informant: Mrs Wm F. Davis
Address: 12 Euclid Place - Cumb. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1947 (month) (day) (year)
Cemetery or crematory: Zion Memorial Park
Location: Cumberland, Md.
18. Funeral director: John J. Hafer
Address: Cumberland Md.
19. Dec 13 1947 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 1947, at 7:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/16/47 19.. to 12/11/47 19..
and that I last saw him alive on 12/11/47 19..

Immediate cause of death	DURATION
Myocardial Failure	
Due to: Hypertensive Cardio Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: R. H. Williams M.D. — M. D. or other
Address: Med. Bldg Cumberland Md. Date signed 12/11/47

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10721

Reg. Diat. No. 9

1. PLACE OF DEATH

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Front Street

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Mary E. Dilfer

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Dilfer

6.(c) If alive, age: ... years

7. Birth date of deceased (mo., day, yr.): Aug. 29th 1880

8. AGE:

Years	Months	Days	If less than one day
67	3	16	... hrs. ... min.

9. Birthplace: Lonaconing, Allegany Co. Md (Town, county and state)

10. Usual occupation: Horse Work

11. Industry or business: Own Home

FATHER

12. Name: Andrew Nicol

13. Birthplace: Scotland

MOTHER

14. Maiden name: Mary Devine

15. Birthplace: Delaware

16. Informant: Mrs. Laura Lancaster

Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland, Md

18. Funeral director: Dr. Eichhorn

Address: Lonaconing, Md

19. 12-17 1947 (Date rec'd by registrar) McHaney N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-15 1947, at 9:39 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-14 1947, to 12-15 1947 and that I last saw h.er alive on 12-15 1947

Immediate cause of death	DURATION
Toxic Myocarditis	3 d.
Due to: Pneumonitis + Grippe	1 wk.
Due to:	
Other conditions: Bronchial asthma	30 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frank T. Harrat M.D. M. D. or other

Address: 59 E. Main St. Frostburg Date signed: 12-17-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

S 10722

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred: 07 Bedford st.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Va. County: Morgan

City or town: Berkley Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Harrison Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Laura Virginia Dyche

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife: Frank Dyche.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1870

8. AGE: Years: 77 Months: 11 Days: 14 If less than one day: ..... hrs. ..... min.

9. Birthplace: Sir Johns Run W. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Peter Ambrose

13. Birthplace: West Va.

MOTHER 14. Maiden name: Sarah Glover

15. Birthplace: West Va.

16. Informant: Mrs Guy Flint

Address: Cumberland Md

17. Burial, cremation, or removal: Removed to Md. Date thereof: 12/19/1947 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Berkley Springs W. Va.

18. Funeral director: Hunter Funeral Home

Address: Berkley Springs W. Va.

19. (Date rec'd by registrar) Dec. 17, 1947 W. R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16, 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Dec 16 1947

and that I last saw h... alive on Dec 16, 1947

	DURATION
Immediate cause of death: Uraemia	10 days
Underlying cause: arteriosclerosis	
Due to: Myocarditis	1 1/2 yrs
Due to: Arteriosclerosis	5 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. R. Turner M. D. or other

Address: Cumberland Date signed: 12/17/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47a

10723

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs 1 mo 23 days.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 710 Cecelia St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Joseph Eirich

3.(b) Social Security Number

4. Sex	5. Color or race	7.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sara C. Harris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 22 1872

8. AGE:

Years	Months	Days	If less than one day
75	1	23	..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Warehouse foreman.

11. Industry or business Warehouse

FATHER 12. Name Martin J Eirich

FATHER 13. Birthplace Cumberland Md

MOTHER 14. Maiden name Sophia Brainer

MOTHER 15. Birthplace Germany.

16. Informant Mrs Cecelia Albright

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 18 47 (month) (day) (year)

Cemetery or crematory St Peter + Paul Cem.

Location Cumberland

18. Funeral director Louis Stein, Inc

Address Cumberland

19. Dec. 17 1947 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1947 at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5 1947 to Dec. 15 1947 and that I last saw h... alive on Dec. 15 1947

Immediate cause of death	DURATION
Carcinoma of Lungs	1-2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE B. M. Schindler MD M. D. or other

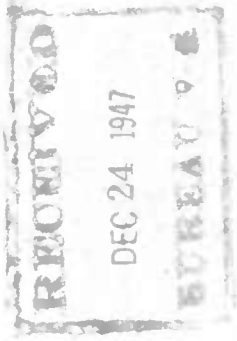
Address 4 Greene St Date signed Dec. 16, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Schindler



MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

Dr P. E. Berry
940
Piedmont, W. Va.

19724

CERTIFICATE OF DEATH

Reg. Diat. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 years
Hospital, institution, or street address where death occurred:
110 Howard Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 110 Howard Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ALICE FAZENBAKER

3.(b) Social Security Number: - - - - - - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Edward Fazenbaker
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): May 13, ~~1947~~ 1880

8. AGE: Years	Months	Days	If less than one day
67	7	1	...hrs. ...min.

9. Birthplace: Mt Savage, Allegany, Maryland
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Own home

FATHER
12. Name: Thomas Evans
13. Birthplace: Mt Savage, Maryland

MOTHER
14. Maiden name: Jane Hostller
15. Birthplace: Mt Savage, Maryland

16. Informant: Mr Arthur Fazenbaker
Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 17, 1947 (month) (day) (year)
Cemetery or crematory: Philos Cemetery
Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland

19. Dec. 17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1947, at 8:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1947, to Dec. 14 1947, and that I last saw her alive on Dec. 11 1947

Immediate cause of death	DURATION
Coronary Thrombosis	7 wks
Due to: arteriosclerosis	5 yrs
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P E Berry M. D. or other
Address: Piedmont W Va Date signed 12/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10725

174

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: (Rural) Mill Run Mine near Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. W. Va. County: Allegany

City or town: Piedmont W. Va.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rex Isaac Frankland

3.(b) Social Security Number: 217-01-9792

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	married

6.(b) Name of husband or wife: Catherine Moran Frankland

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): May 12, 1899

8. AGE: Years: 48 Months: 7 Days: 3 If less than one day: ...hrs. ...min.

9. Birthplace: Westernport, Allegany, Maryland (Town, county and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER — 12. Name: Lee Frankland

FATHER — 13. Birthplace: Westernport, Md

MOTHER — 14. Maiden name: Amanda Fortney

MOTHER — 15. Birthplace: Westernport, Maryland

16. Informant: Mrs ~~Frank~~ Catherine Frankland

Address: Piedmont, W. Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 18, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland.

19. Dec. 17 1947 (Date rec'd by registrar) H. Baynhaker M.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1947, at 11:15 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19... to ...19...

and that I last saw h. I.M. Dead ...1947

Immediate cause of death	DURATION
Intracranial hemorrhage	at once
Due to: Fracture of the skull	
Due to: fall of Slate coal	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 12-15-1947

Where did injury occur? near Barton (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) Coal Mine, Mill Run near Barton Md

Means of injury: Fall of Slate coal Injured at work? Yes

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. M. D. or other

Address: Cumberland Md Date signed: 12-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J A15 9-45-15M

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 a

10726

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL, CUMBERLAND, MD.
How long in hospital or institution? 19 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County PRESTON
City or town CORINTH
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MAE FREELAND

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife SAMMY FREELAND
6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) JAN. 4, 1904

8. AGE: Years	Months	Days	If less than one day
43	11	26	hrs. min.

9. Birthplace W.VA. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name KENNETH FRANKHOUSER
13. Birthplace W.VA.
MOTHER 14. Maiden name SARAH FELTON
15. Birthplace W.VA.
16. Informant Like-Watson Funeral Home
Address Terra Alta, W. Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 1, 1948 (month) (day) (year)
Cemetery or crematory Terra Alta Cem.
Location Terra Alta, W. Va.
18. Funeral director Preston R. Watson
Address Terra Alta W. Va.
19. Dec. 31, 1947 (Date rec'd by registrar) Ted R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 30, 1947 at 1:58 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-11- 19 47 to 12-30- 19 47
aed that I last saw h alive on 19
Immediate cause of death Arteriosclerotic nephro-sclerosis. — DURATION ?
Due to
Due to
Other conditions Cardiac Hypertrophy
(include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson, M.D.
Address Cumberland, Md. M. D. or other
Date signed 12-31-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63c

10727

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 8 months

Hospital, institution, or street address where death occurred:

Miner's Hospital

How long in hospital or institution? 1 Month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckman R. D. No 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Edith Lucinda Tanner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Earl Tanner

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Sept. 5 - 1894

8. AGE:

Years	Months	Days	If less than one day
53	3	17	..... hrs. ..... min.

9. Birthplace: Lannes Township, Pa.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: George Ernest

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Lydia Mayer

15. Birthplace: Pennsylvania

16. Informant: Mr. Earl Tanner

Address: R. D. No 2 Box 18 Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-47 (month) (day) (year)

Cemetery or crematory: Rhinto Oak

Location: Legal Pa.

18. Funeral director: Jacob Yates

Address: Frostburg Md.

19. 12-23 1947 Mrs Hally N Rea Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 - 20 1947 at 7.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/20 1947 to 12/20 1947 and that I last saw h er alive on 12/20/47 19.....

Immediate cause of death	DURATION
Toxic Myocarditis	3 mos
Due to: Toxic Hyperthyroidism	3½ yrs (?)
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank T. Harrat M.D. M. D. or other

Address: 59 E. Main St. Frostburg Md. Date signed 12/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

10728

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? + 4½ days
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 4½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Lake Lynn Mt. (If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. No. 1 Frostburg, Md. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lillie Gertrude Giles

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widowed

6.(b) Name of husband or wife: Thomas Giles
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 20 - 1872

8. AGE:

Years	Months	Days	If less than one day
74	5	20	..... hrs. ..... min.

9. Birthplace Berkley Co. W. Va. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name John Harrington
13. Birthplace Berkley County, W. Va.

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mrs. Mabel Riley
Address Hoye Road, Frostburg
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 - 12 - 1947 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.
18. Funeral director Jacob Baker
Address Frostburg, Md.
19. 12 - 15 1947 Mrs. Nancy H. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1947 at 1:36 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 6 1947, to Dec 10 1947
and that I last saw her alive on Dec 9 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	4 Days
Due to Hypertension	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wm Lane M.D. M. D. or other
Address Frostburg Md. Date signed 12-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

10729

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Miner's Hospital

How long in hospital or institution? about 11 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. East Main St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Annie Doyle Gillies

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife Abram Gillies

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) - - - 1873

8. AGE: Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace Lonaconing Allegany Co Md

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

FATHER 12. Name James Doyle

13. Birthplace Nova Scotia

MOTHER 14. Maiden name Frazer

15. Birthplace Unknown

16. Informant Mrs Catherine Freeman

Address Lonaconing, Md

17. Burial Date thereof Dec 30, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland Md

18. Funeral director M. Eichhorn

Address Lonaconing Md

19. 12-30 1947 Mrs Nancy N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1947 at 3.30 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.E.R. alive DEAD Dec 30 1947

Immediate cause of death	DURATION
Pulmonary embolus	at once
Due to Fracture of left femur	about 1½ days
Due to Slipped and fell on ice in front of home	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-27-47

Where did injury occur Lonaconing Allegany Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In front of home

Means of injury Slipped on ice Injured at work? No

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D.

M. D. or other

Address Cumberland Md Date signed 12-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 b

10730

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany

City or town Shaft Woods

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Months

Hospital, institution or street address where death occurred: Station, Mt. Savage, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Baltimore Balto Co.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 S. Easton Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah Jane Blackburn Dolnick

3. (b) Social Security Number 232-26-2089

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Chester A. Dolnick

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30 - 1876

8. AGE: Years	Months	Days	If less than one day
71	6	29	..... hrs. ..... min.

9. Birthplace Antioch W. Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Ladies Clothing Store

FATHER 12. Name Thos. Blackburn

13. Birthplace Antioch, W. Va.

MOTHER 14. Maiden name Sarah Rezenberger

15. Birthplace Antioch, W. Va.

16. Informant Station, Mt. Savage, Md.

Address Carl D. Dolnick

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-31-1947 (month) (day) (year)

Cemetery or crematory Sugar Lands Cem.

Location Thurmont, Md.

18. Funeral director Paul D. Fox

Address Hagerstown, Md.

19. Dec 30 1947 (Date received by registrar) Thomas McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29th 1947 at 1:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to Dec - 28th 1947

and that I last saw h[illegible] alive on Dec - 28th 1947

Immediate cause of death Carcinoma Stomach and Liver - (DURATION)

Due to

Due to

Other conditions Secondary involvement of Rectum

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Moseley M. D. MD, or other

Address Mt Savage Md. Date signed 12-29-1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits: Whitworth

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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10731

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Bowmans Addition

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. 3 Cumberland Md. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joann Hoole

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 11, 1947

8. AGE:

Years	Months	Days	If less than one day
0	8	6	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER

12. Name: James D. A. Hoole

13. Birthplace: Shaneyville, Pa.

MOTHER

14. Maiden name: Emma Wright

15. Birthplace: Green Ridge, Pa.

16. Informant: James D. Hoole

Address: R.D. 3 - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 18, 1947 (month) (day) (year)

Cemetery or crematory: Rite Cemetery

Location: Near Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 18, 1947 (Date rec'd by registrar) W. H. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 1947, at 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to 16 Dec 1947 and that I last saw her alive on 16 Dec 1947

Immediate cause of death	DURATION
Late Pregnancy	
Bilateral	
Due to: Repeat Respiratory Injuries	
Due to:	
Other conditions: Toxic Nurses	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Julius B. Hurlbert M. D. or other

Address: 112 Bedford St. Date signed: 17 Dec

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10732

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Rural) Old Town
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 1 Oldtown
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Patricia Ann Hook

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 20- 1947

8. AGE:

Years	Months	Days	If less than one day
0	9	24	____ hrs. ____ min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Arthur Gaines Hook
13. Birthplace: Cumberland Md.

MOTHER
14. Maiden name: Mary Monnette
15. Birthplace: Cumberland Md.

16. Informant: Arthur G Hook
Address: Rt 1 Oldtown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16 47 (month) (day) (year)

Cemetery or crematory: Int Fairview Cem.

Location: Spring Gap, Md.

18. Funeral director: Lonnie Stein Inc

Address: Cumberland Md.

19. Dec 16 19 47 (Date rec'd by registrar) W.K. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec, 14 19 47 at about 7.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__ and that I last saw her alive on Dead Dec. 14 19 47

Immediate cause of death	DURATION
Tracheal Bronchitis	about 1 week
also had	
*** Due to Bronchial Pneumonia (Hemorrhagic)	
** Due to and mucus plugs in bronchi	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed 12-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 10733

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, Institution, or street address where death occurred: 321 Pulaski St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 321 Pulaski

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Ada Cecelia Horn

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm J Horn

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 14 1865

8. AGE: Years: 82 | Months: 8 | Days: 12 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Reuben Bower

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Eliza Sawyer

15. Birthplace: Pa.

16. Informant: Paul W. Horn

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 29 47 (month) (day) (year)

Cemetery or crematory: Mt Carmel Cem

Location: Williamsport Pa

18. Funeral director: Louis Stein

Address: Cumberland, Md

19. Dec 29 1947 (Date rec'd by registrar) W. K. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1947 at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1947 to Dec 26 1947 and that I last saw h[illegible] alive on Dec 26 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 wks
Due to: Hypertension Heart	5 yrs
Due to: Cancer	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland 2nd Date signed: Dec 28 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10734

93d

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Flintstone Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Rural

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: Bedford

City or town: Artemas
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Ellsworth Humbertson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ellen Peterson

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 22-1874

8. AGE: Years	Months	Days	If less than one day
73	8	2	....hrs. ....min.

9. Birthplace: Cumberland, Alleagny Co, Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER — 12. Name: George Humbertson

FATHER — 13. Birthplace: Meyersdale, Pa

MOTHER — 14. Maiden name: Belle Boggs

MOTHER — 15. Birthplace: Lonaconing, Md.

16. Informant: Jerome Humbertson

Address: 31 Mt Pleasant St, Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/28/47 (month) (day) (year)

Cemetery or crematory: Porter Cemetery

Location: Eckhart, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec 27 1947 (Date rec'd by registrar) Nina L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1947 at 3.15P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw him alive Dead Dec. 24 1947

Immediate cause of death	DURATION
Chronic Myocarditis	several years
Due to	
Due to	
Other conditions arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V.Deming M.D. H.V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 12-24-47

W

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10735

107

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Rural) Sunny Side, near Mt Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Md.
Brought to Miner's Hospital, Frostburg

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Rural) Sunny Side, near Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rosetta Marie Imes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6-1946

8. AGE: Years	Months	Days	If less than one day
1	0	15	hrs. min.

9. Birthplace Mt. Savage, Allegany, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Thomas F. Imes

13. Birthplace Mt. Savage Md.

MOTHER 14. Maiden name Viola Gordon

15. Birthplace Magnolia W.Va.

16. Informant Mother

Address R.F.D. Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-1947 (month) (day) (year)

Cemetery or crematory Sunnyside Cemetery

Location Below Mt. Savage, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 12-27 1947 Mrs Nancy K. Rice Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 19 47 at 1015A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 , to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Bronchopneumonia	1week
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md Date signed 12-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10736

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No.: None

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Carolyn Elaine James

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 9, 1947

8. AGE: Years: — Months: 2 Days: 21 If less than one day: hrs. min.

9. Birthplace: Miners Hospital Frostburg Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: Clinton James

13. Birthplace: Lonaconing Md.

MOTHER — 14. Maiden name: Vera Eldine Donald

15. Birthplace: Knapps Meadow, Lonaconing, Md.

16. Informant: Clinton James

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31, 1947 (month) (day) (year)

Cemetery or crematory: Old Carey Cemetary

Location: Lonaconing Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. 12-31 1947 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1947 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29 1947 to Dec 29 1947 and that I last saw h. alive on Dec 29 1947.

	DURATION
Immediate cause of death: Broncho-pneumonia	2 days
Due to: —	
Due to: —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. E. Gatten M.D. M. D. or other

Address: Frostburg Md. Date signed 12/31/47

Within corporate limits

W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

10737

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MDARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 weeks
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 165 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. RT. # 6 BOWLING GREEN
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JENKINS, ELICK J. ~~Sr.~~

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	~~MARRIED~~ Widowed

6.(b) Name of husband or wife HARDY, MAY deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB. 4, 1878

8. AGE: Years	Months	Days	If less than one day
69	10	27	..... hrs. ..... min.

9. Birthplace W. VA. (Town, county, and state)
10. Usual occupation Grocer
11. Industry or business Own business
FATHER 12. Name JENKINS, JOSEPH
13. Birthplace W. VA.
MOTHER 14. Maiden name JENKINS, JANE
15. Birthplace PA.
16. Informant Elmer Jenkins
Address Bowling Green, Rt. #6, City
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3, 1948 (month) (day) (year)
Cemetery or crematory Woodrow church Cemetery
Location Woodrow, W. Va.
18. Funeral director John J. Hafer
Address Cumberland, Md.
19. Jan 3 1948 (Date rec'd by registrar) W.A. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 31 1947 at 10:25 M P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-24-1947 to 12/31/1947 and that I last saw him alive on 12/31/1947

Immediate cause of death	DURATION
Diabetes Mellitus	
Gangrene	
Due to Left Leg	
Due to Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Amputation Left Leg Date of op. 12/5/47
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W.F. Williams M. D. or other
Address Cumberland Date signed 12/48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1221

10738

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4.1/2 hrs.

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 4.1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Flintstone
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Larry Stanley Jordan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 2 -1947

8. AGE: Years	Months	Days	If less than one day
**********	4	9	____ hrs. ____ min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER

12. Name: Blaine J. Jordan

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Elizabeth M. Phillips

15. Birthplace: Penna.

16. Informant: Blaine J. Jordan

Address: Flintstone Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec 15 47 (month) (day) (year)

Cemetery or crematory: Methodist Cem.

Location: Flintstone Md.

18. Funeral director: Lonio Stein Inc.

Address: Cumberland

19. Dec 13 1947 (Date rec'd by registrar) W.R. Trantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__

and that I last saw him alive Dead Dec. 11 1947

Immediate cause of death	DURATION
Intussusception	about 4 days
** Dehydration due to diarrhoea	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or C.

Address: Cumberland Md. Date signed 12-11-47

Within corporate limits

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108

10739

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL Hospital

How long in hospital or institution? 16 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PENNA. County Bedford

City or town BEDFORD, PA.
(If outside city or town limits, write RURAL and give nearest town)

Street No. RT. #3 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM CLETUS KARNS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 21, 1947

8. AGE: Years | Months: 2 | Days: 4 | If less than one day: hrs. min.

9. Birthplace PA. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name ROBERT A KARNS
13. Birthplace PA

MOTHER
14. Maiden name HAZEL SMITH
15. Birthplace PA.

16. Informant Edward Pate
Address Bedford, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 26 47 (month) (day) (year)

Cemetery or crematory Bortz Lutheran

Location Bedford, Pa

18. Funeral director Edward Pate,

Address Bedford, Pa.

19. Dec 26, 1947 (Date rec'd by registrar) W.K. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 25, 1947 at 11:13A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Dec 1947 to 25 Dec 1947 and that I last saw h[illegible] alive on 25 Dec 1947

Immediate cause of death	DURATION
Meningitis (Pneumococcus)	
Due to Lobar Pneumonia	
Due to	
Other conditions Convulsions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fully B Whitworth M.D.
M. D. or other

Address 112 Bedford St. Date signed 25 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C

10740

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany Cumberland
City or town rural-Route#35 near ~~Barrellsville~~
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few minutes
Hospital, Institution, or street address where death occurred:
Enroute to Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town [redacted] r Barrellsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. [redacted] 5
(If rural, give LOCATION)
2.(a) If veteran, name war II World War

3.(a) FULL NAME
William Robert Kelley

3.(b) Social Security Number
213-22-7662

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Rose Ann Bishop
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 2-1927

8. AGE:

Years	Months	Days	If less than one day
20	11	19	..... hrs. ..... min.

9. Birthplace Barrellsville Md
(Town, county, and state)
10. Usual occupation Miner
11. Industry or business Coal Mining

FATHER
12. Name Joseph L.Kelley
13. Birthplace Midland Md.

MOTHER
14. Maiden name Mary Pearl O' Baker
15. Birthplace Narrow's Park Md.

16. Informant Joseph L. Kelley
Address Barrellsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-47 (month) (day) (year)
Cemetery or crematory St Peter & Paul Cem.
Location Cumberland Md
18. Funeral director Louis Stein Jr
Address Cumberland

19. Dec 23 1947 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1947 at about 1.35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on Dead Dec. 21 1947

Immediate cause of death	DURATION
Fracture of the 3rd cervical	about 5
vertebrae & severe concussion	minutes
Due to of the brain	
Due to Automobile Accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 12-21-47
Where did injury occur near Barrellsville (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) Highway route #35
Means of injury Auto. hit culvert Injured at work? No

Deputy Medical Examiner - Allegany Co. Md.

23. SIGNATURE H.V.Deming M.D. H.V. Deming M.D.
M. D. or Coroner
Address Cumberland Md. Date signed 12-22-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Insert correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10741

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 years

Hospital, institution, or street address where death occurred:
122 Paca St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 122 Paca St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alfred Joseph Kienhofer

3. (b) Social Security Number: 705-05-4367

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife: Frances Reynolds

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 8 1903

8. AGE: Years	Months	Days	If less than one day
44	6	8	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Crane operator

11. Industry or business: Boiler Shop, R.R. Co.

FATHER
12. Name: Joseph Kienhofer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Rice
15. Birthplace: Maryland

16. Informant: Mrs. Josephine Hutton
Address: 122 Paca Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18, 47 (month) (day) (year)

Cemetery or crematory: SS. Peter & Paul

Location: Cumberland, Maryland

18. Funeral director: Charles L. George
Address: 202 Green St.

19. Dec. 18, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1947 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Dec 15 1947 and that I last saw h.. alive on Dec 1st (about) 1947

Immediate cause of death: Myelogenous leukemia — DURATION: 6 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. R. Trevaskis, Jr., M.D.
M. D. or other

Address: Cumberland, Md Date signed: Dec 16-47

Within corporate limits

DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

10742

CERTIFICATE OF DEATH

UB 7 4

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 Days

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 41 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

WEST VIRGINIA

State ..... County Mineral

City or town ELK GARDEN

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME GEORGE WAYMAN KITZMILLER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife MARTHA ( ) KITZMILLER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DECEMBER 12 1874

8. AGE: Years	Months	Days	If less than one day
72	11	25	..... hrs. ..... min.

9. Birthplace MARYLAND

(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER

12. Name ALEX KITZMILLER

13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden name CORA LEWIS

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/47 (month) (day) (year)

Cemetery or crematory Odd Fellows Cemetery

Location Elk Garden, W. Va.

18. Funeral director O.F. Sharpless

Address Blaine, W. Va.

19. Dec. 8 1947 (Date rec'd by registrar) W.L. Stantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 7, 1947 19..... at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1947 to Dec 7 1947 and that I last saw h.. alive on Dec 6 1947

Immediate cause of death	DURATION
(a) Retroperitoneal Cell Sarcoma	1 year?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Sarcoma Rt. Lung region Date of op. 11-18-47

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F.M. Wagner M. D. or other

Address Cumberland Md Date signed 12-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462

10743

Reg. Dist. No. 9

W

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 123 S. Water
(If rural, give LOCATION)
2.(a) If veteran, name war: First World War

3.(a) FULL NAME: James Martin Knepp

3.(b) Social Security Number: 213-05-7133

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amy Cooper
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): April 18 1899

8. AGE:

Years	Months	Days	If less than one day
48	7	29	hrs. min.

9. Birthplace: Glencoe Pa.
(Town, county, and state)

10. Usual occupation: Steward

11. Industry or business: American Legion Club

FATHER
12. Name: Theodore Knepp
13. Birthplace: unknown

MOTHER
14. Maiden name: Catherine Mathias
15. Birthplace: unknown

18. Informant: Mrs James Knepp
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 20 1947 (month) (day) (year)
Cemetery or crematory: Allegany Cemetary
Location: Frostburg Md.

18. Funeral director: J. R. Durst
Address: Frostburg Md.

19. 12-18 1947 Mrs. Nancy L. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 1947 at 1:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8, 1947 to Dec 17 1947 and that I last saw h--- alive on Dec 16 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm C Lane MD
M. D. or other
Address: Frostburg Md Date signed: 12-18-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

10744

DR. TOPPER

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL, CUMBERLAND, MD.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNA. County Bedford
City or town HYNDMAN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Beverly Ann ~~BABY GIRL~~ KORNS

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 7, 1947

8. AGE: Years	Months	Days	If less than one day
		2	..... hrs. ..... min.

9. Birthplace ALLEGANY, CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name JOHN KORNS
13. Birthplace PENNA.

MOTHER
14. Maiden name AIMEDA SHROYER
15. Birthplace PENNA

16. Informant John Korns
Address Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/ 12/47 (month) (day) (year)
Cemetery or crematory Porter
Location Hyndman, Pa.

18. Funeral director Harvey H. Zeigler
Address Hyndman, Pa.

19. Dec 12 1947 (Date rec'd by registrar) W.L. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 9 1947 at 1:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1947 to Dec 9 1947 and that I last saw h. alive on Dec 9 1947

Immediate cause of death	DURATION
Pulmonary atelectasis	24 hrs.
Due to	
Due to	
Other conditions Prematurity - Twin gestation	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Lee C. Topper M.D. M. D. or other.
Address Hyndman Pa. Date signed 12/9/47

W C I H

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

10745

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Mt. Pleasant St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nettie Krapf

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 6, 1875

8. AGE: Years: 72 | Months: 0 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg Allegany Co., Md.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: Zacharias Krapf

13. Birthplace: Germany

MOTHER

14. Maiden name: Sarah Geis

15. Birthplace: Maryland

16. Informant: Mrs. Sarah Rauth

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. R. Durbt

Address: Frostburg Md.

19. 12-18 1947 Mrs. Nancy N. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 1947 at 12:32 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19.. to Dec 17 1947 and that I last saw her alive on Dec 16 1947

	DURATION
Immediate cause of death: Massive Pulmonary Embolism	Sudden
Due to: Chr Myocarditis	several years
Due to:	
Other conditions: Chr Nephritis.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W M Lane M D M. D. or other

Address Frostburg Md Date signed 12-18-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10746

932

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Stanton St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George L. Kratzburg

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Annie Byrnes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 20th. 1867

8. AGE: Years 80 | Months 2 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Frostburg Alley, Md.
(Town, county, and state)

10. Usual occupation Retired Miner

11. Industry or business Coal Mines

FATHER 12. Name Conrade Kratzburg

13. Birthplace Germany

MOTHER 14. Maiden name Margaret Bartlett

15. Birthplace Germany

16. Informant Mrs. Terrance Byrnes

Address 79 Bowery St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-1948 (month) (day) (year)

Cemetery or crematory St. Michaels Cem.

Location Frostburg, Md.

18. Funeral director Jacob Kaplan

Address Frostburg, Md.

19. 12-31 1947 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1947 at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1947 to Dec 30 1947 and that I last saw h.. alive on Dec 29 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	several years
Due to: Auricular Fibrillation	? ?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. H. McLane M.D.
M. D. or other

Address Frostburg Md Date signed Dec 30 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92C

10747

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all of life

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland, County Allegany

City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Cash Valley Road
(If rural, give LOCATION)

2.(a) If veteran, name war World War # 2

3. (a) FULL NAME Robert A. Lanham, Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Dorothy Meyers Lanham

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) February 25, 1913

8. AGE: Years 34 | Months ~~Eds~~ 9 | Days 7~~25~~ | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business X

FATHER
12. Name Robert A. Lanham, Sr.
13. Birthplace Norfolk, Virginia

MOTHER
14. Maiden name Edith Webb
15. Birthplace Ridge County, W.Va.

16. Informant James R. Lehman
Address RR#1 City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4, 1947 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Bedford Road, Cumberland, Md.

18. Funeral director John C. Wickard
Address 125 S Liberty St

18. Dec 3 1947 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1947, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 1947, to December 2 1947

and that I last saw him alive on December 2 1947

Immediate cause of death	DURATION
Subacute Bacterial Endocarditis	1 month (uncertain)
Due to Old Rheumatic Valvular Disease with superimposed Staphylococcus Aureus Blood Stream Infection	2 years (uncertain)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Subacute Bact. Endocarditis, Dr's as above Date of op. .....

Autopsy results multiple infarcts spleen, brain, kidneys

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A G Wiseman M D
M. D. or other

Address 122 Bedford St Date signed 12/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

10748

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

DR. W. F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? [redacted]

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 618 VIRGINIA AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME LEARY, HAMILTON MR.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife GOLDIE YANKEE
DECEASED 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 18, 1865

8. AGE: Years	Months	Days	If less than one day
82	9	26	..... hrs. ..... min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER
12. Name MR. JIM LEARY (DECEASED)
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name MRS. KERNS (DECEASED)
15. Birthplace WEST VIRGINIA

16. Informant Clarence C. Leary
Address 618 Virginia Ave. Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 17, 1947 (month) (day) (year)

Cemetery or crematory Allegany Co. Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Dec 17 1947 (Date rec'd by registrar) W. R. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 14 19 47 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11 19 47 to Dec. 14 19 47

and that I last saw h[illegible] alive on Dec. 13 19 47

Immediate cause of death	DURATION
Due to Asphyxiation	
Due to Burns	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 12/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10749

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63-6-24

Hospital, Institution, or street address where death occurred: 227 Pear St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 227 Pear St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Edward Lehman

3.(b) Social Security Number: 217-10-4441

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian Hockler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 6 1884

8. AGE:

Years	Months	Days	If less than one day
63	6	24	..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Foreman, Celanese

FATHER

12. Name: Espy Lehman

13. Birthplace: Pa

MOTHER

14. Maiden name: Elizabeth ——

15. Birthplace: Unknown

16. Informant: Wm E Lehman Jr.

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2 '48 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Dec 31 19 47 (Date rec'd by registrar) C.K. Bantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 19 47 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 46 to December 19 47 and that I last saw h... alive on December 30 19 47.

	DURATION
Immediate cause of death: Coronary Thrombosis	14 hours
Due to: Coronary heart disease	2 years.
Due to:	
Other conditions: Myocardial failure	2 years.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: Richard W. Trevaskis, Jr. M.D. M. D. or other

Address: Cumberland, Md. Date signed: Dec 31, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10750

CERTIFICATE OF DEATH

Reg. Diat. No. 4

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months 12 Days

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? Six Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 N Ceder St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Lee Leslie

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 17 1947

8. AGE: Years	Months	Days	If less than one day
	3	12	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Micheal Leslie

13. Birthplace: Keyser, W. Va.

MOTHER

14. Maiden name: Betty Jane Cook

15. Birthplace: Corriganville, Md.

16. Informant: Micheal Leslie

Address: 109 N Ceder St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/1/48 (month) (day) (year)

Cemetery or crematory: Cooks Mills Cemetery

Location: Cooks Mills Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec 31 19 47 W. R. Beauty M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 19 47 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 19 47 to December 29 19 47 and that I last saw h.. alive on December 29 19 47

Immediate cause of death: Bronchial Pneumonia — DURATION: 5 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Johnson Jr. M.D. M. D. or other

Address: Cumberland Md Date signed 12-30-47

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

10751

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: Rt. 40 West 6 Mile House

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 40 West 6 Mile House
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Archibald Longerbeam

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Etta L. Van Bibber

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23 1870

8. AGE:

Years	Months	Days	If less than one day
77	7	23	..... hrs. ..... min.

9. Birthplace Berryville, Virginia
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER
12. Name Charles Longerbeam
13. Birthplace Va.

MOTHER
14. Maiden name Mary Bell
15. Birthplace Va.

16. Informant Mrs Helen Keller
Address Rt 40 6 Mile House

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-19-47 (month) (day) (year)

Cemetery or crematory Green Hill Cem.

Location Berryville Va.

18. Funeral director Louis Steinhauer

Address Cumberland

19. Dec 18, 1947 (Date rec'd by registrar) W. R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to Dec 16 1947 and that I last saw him alive on Dec 15 1947

Immediate cause of death	DURATION
Coronary Thrombosis	12 hrs
Due to Chronic Endocarditis and Myocarditis	8 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Alan Green M. D. or other

Address Cumberland Date signed Dec 18 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Murray

Outside of City Limits

10752

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Lavale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Lavale Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Lavale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Emma Ludwig

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Dr Geo. W. Ludwig

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 21, 1860

8. AGE: Years	Months	Days	If less than one day
87	11	1	..... hrs. ..... min.

9. Birthplace Cumberland, Md. (Town, county and state)

10. Usual occupation Housewife

11. Industry or business own home

FATHER 12. Name Jacob Brengle

13. Birthplace ?

MOTHER 14. Maiden name Elizabeth Boogher

15. Birthplace ?

16. Informant James Beachaga

Address Lavale, Md.

17. Burial Date thereof Dec 24, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Dec. 24 1947 W.R. Hantz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14 1947 to Dec. 22 1947

and that I last saw h.. alive on Dec. 21 1947

Immediate cause of death	DURATION
Pulmonary Embolism	Unknown
Due to Calf vein thrombosis	
Due to	
Other conditions Pulmonary infarcts	10 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.R. Hodges, M.D.

Address Cumberland, Md M. D. or other

Date signed 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

ALLEGANY COUNTY HEALTH DEPARTMENT
CUMBERLAND, MARYLAND

INTER OFFICE COMMUNICATION

Date January 2, 1948

To: Dr. A. W. Hedrich

From: Dr. W. R. Frantz

Remarks:

Dear Dr. Hedrich:

The attached certificate was not given to this office until this morning January 2, 1948 although a burial-transit permit was issued by the Police Department on December 24, 1947. This has happened several times in the past because the Police Department files them with other papers or misplaces them. We have talked with them about this matter, but they do not seem to care and we cannot force them.

Trusting this will not inconvience your office too much, I am

Yours truly,

W. R. Frantz, M.D.

W. R. Frantz, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10753

114e

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Joseph Aloysius McGowan

3.(b) Social Security Number: 216-05-2005

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife: Mary McCabe
6.(c) If alive, give age: 2 years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1887.

8. AGE: Years: 60 | Months: 11 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Davis Mt. Near Lonaconing Md. (Town, county, and state)
10. Usual occupation: Coal Mining (Retired)
11. Industry or business: Consol. Coal Co.
FATHER 12. Name: John McGowan
13. Birthplace: Scotland
MOTHER 14. Maiden name: Mary E. Nolan
15. Birthplace: Ireland
16. Informant: John McGowan
Address: Midland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 30, 1947 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Md.
18. Funeral director: J. E. Fichtner
Address: Lonaconing, Md.
19. 12-28 1947 (Date rec'd by registrar) Mrs. Nancy N. Poe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-27 1947, at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-7 1947, to 12-27 1947 and that I last saw him alive on 12-27 1947

Immediate cause of death	DURATION
Respiratory failure	1 hr.
due to Chronic Bronchial asthma	15 yrs.
due to Anthracosis	?
Other conditions: Spastic colitis	8 mos.
Senility	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank T. Harriet M.D. (M. D. or other)
Address: 59 E. Main St. Frostburg Date signed: 12-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45 C

10754

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH.
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 LAING AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
JAMES MC KALVEY

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Widowed

6.(b) Name of husband or wife MARY REED
6.(c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1875

8. AGE: Years	Months	Days	If less than one day
72	1	24	hrs. min.

9. Birthplace Williamsport, Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name ELICK MC KALVEY
13. Birthplace MARYLAND

MOTHER
14. Maiden name MARY SINGER
15. Birthplace VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 15, 1947 (month) (day) (year)
Cemetery or crematory Riverview Cem.
Location Williamsport, Md.
18. Funeral director Charles L. George
Address Cumberland, Md.

19. Dec 13 1947 (Date rec'd by registrar) W. P. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 12-12-1947 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5 1947 to 12-12-1947 and that I last saw him alive on 12-12-1947

	DURATION
Immediate cause of death: Complications of Diabetes Mellitus of	
Due to: Mouth & Throat Cancer	
Due to: Carcinoma of tongue	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams 12/13/47 M. D. or other
Address Cumberland Date signed M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Miss Skinner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10755

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Depot St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gloria Jean McKee

3.(b) Social Security Number: none

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 25 1947

8. AGE: Years: | Months: 3 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg Allegany, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: John Short

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Edith McKee

MOTHER — 15. Birthplace: Maryland

16. Informant: Edith McKee

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg Md

18. Funeral director: R. Dirst

Address: Frostburg Md.

19. 12-8 1947 (Date rec'd by registrar) Mrs Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 5 1947, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1947, to Dec 5 1947, and that I last saw her alive on Dec 5 1947.

Immediate cause of death	DURATION
Bronchopneumonia	? ?
Primary	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: W O McLane M D (M. D. or other)

Address: Frostburg Md Date signed: 12-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d 10756

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address (where death occurred): Consolidation Coal Co., Frostburg, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 270
(If rural, give LOCATION)

2.(a) If veteran, name war: First World War

3.(a) FULL NAME: Blair Martin Mellott

3.(b) Social Security Number: 705-09-8697

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Mellott

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 22, 1896

8. AGE:

Years	Months	Days	If less than one day
51	1	19	____ hrs. ____ min.

9. Birthplace: Bucks Valley, Telktown, Pa.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: railroad

FATHER 12. Name: Daniel Mellott

13. Birthplace: unknown

MOTHER 14. Maiden name: Sarah True

15. Birthplace: unknown

16. Informant: Mrs. Elizabeth Mellott

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg, Md.

18. Funeral director: J. R. Durst

Address: Frostburg, Md.

19. 12-14 19 47 Mrs. Harvey N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-11 1947 at 10 10/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/17 1947 to 12-9 1947 and that I last saw h... alive on 12-9-47 1947

Immediate cause of death	DURATION
Acute congestive failure (cardiac)	2 hrs
Due to: Chronic aortitis	?
" aortic valvulitis	?
Due to: Infection by Treponema Pallidum	
Other conditions: naso-pharyngo-tracheo-bronchitis (gastro-enteritis)	12 d. → 12 hrs

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Frank T. Hamer M.D.
M. D. or other

Address: 59 E. Main St. Frostburg Md. Date signed: 12/12/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

10757

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Hrs. & 40 minutes

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 6 Hrs. & 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 218 Arch St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James R. Murphy

3. (b) Social Security Number 705-07-9514

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Virginia Files Murphy

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Jan. 9. 1895

8. AGE: Years	Months	Days	If less than one day
52	11	13	....hrs. ....min.

9. Birthplace Jones Spring, Berkeley Co., W. Va.
(Town, county, and state)

10. Usual occupation B&O. R. Ry freight conductor

11. Industry or business

FATHER 12. Name Warner Murphy

13. Birthplace Jones Springs, W. Va.

MOTHER 14. Maiden name Catherine Coffinbarger

15. Birthplace Jones Springs, W. Va.

16. Informant Mrs. J. R. Murphy

Address 218 Arch St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 26, 1947 (month) (day) (year)

Cemetery or crematory New Norborn Cemetery

Location Martinsburg W. Va.

18. Funeral director John F. Hafer

Address Cumberland, Md.

19. Dec 26 1947 (Date rec'd by registrar) Hunter R. Trout, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 19 47 at 4.40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw him alive Dead Dec. 22 19 47

Immediate cause of death	DURATION
Cerebral contusion left	about
temporal region, marked	7 hrs.
** cerebral edema	
also had calcified aortic valve	
*** moderate coronary sclerosis	
Due to- accidently slipped on	
**** roof of car, due to heavy	
dew, struck head on ballast.	

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-22-47

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) East bound hump B&O. R. Ry

Means of injury as above Injured at work? 12-22-47

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 12-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

10758

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29-7-13

Hospital, institution, or street address where death occurred: 217 Carroll St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Carroll St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Effie Reff

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 14 1868

8. AGE:

Years	Months	Days	If less than one day
79	7	13	..... hrs. ..... min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Wm. Reff

13. Birthplace: Va.

MOTHER — 14. Maiden name: Caroline Suter

15. Birthplace: Md.

16. Informant: Mrs Tessa Little

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Dec 30 1947 W. R. Trautz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1947 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 47 1947 to 27 Dec 1947 and that I last saw h[illegible] alive on Dec 45 1947

Immediate cause of death	DURATION
atherosclerotic heart disease with Cardiac	
Due to: arrest.	2 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. Alfred Va Dems M. D. or other

Address: Cumberland. Md Date signed 29 Dec 47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

10759

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town 11 Smith St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, Institution, or street address where death occurred:
11 Smith St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Smith St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Miss Josephine O'Leary

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 29-1869

8. AGE:

Years	Months	Days	If less than one day
78	8	2	..... hrs. ..... min.

9. Birthplace Martinsburg W. Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name John O'Leary
13. Birthplace Ireland

MOTHER
14. Maiden name Julia O'Connor
15. Birthplace Ireland

16. Informant Mrs. Helen Stein

Address 617 Bedford St City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4 '47 (month) (day) (year)

Cemetery or crematory St Peter & Paul Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Dec. 3 1947 (Date rec'd by registrar) Carl Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1947 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on Dead Dec. 1 1947

Immediate cause of death Coronary occlusion — DURATION: at once

Due to arteriosclerosis — DURATION: several years

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. Examiner

Address Cumberland Md. Date signed 12-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

10760 9

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 51 Armand

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Lavinia Betz Ort

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Conrad Ort

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 4 - 1854

8. AGE: Years	Months	Days	If less than one day
93	10	8	..... hrs. ..... min.

9. Birthplace: Frostburg - alleg - md

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Jacob Betz

13. Birthplace: St. Ingbert, Bavaria

MOTHER

14. Maiden name: Josephine Phillippe Heinty

15. Birthplace: Wesenburg France

16. Informant: Gertrude Williams

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 14 1947 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md.

18. Funeral director: J. R. Durst

Address: Frostburg, md.

19. 12-15 1947 (Date rec'd by registrar) Mrs. Nancy K. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 1947 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 27 1947, to Dec 12 1947

and that I last saw h er alive on Dec 11 1947

Immediate cause of death	DURATION
Fracture of Rt Femur	15 Days
Due to	
Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of Nov 27 1947

Where did injury occur? Frostburg (City or town) alley (Country) Md (State)

Injured at home, farm, industry, public place (where?) None

Means of injury Fell in room Injured at work? No

23. SIGNATURE: W. M. Lane M.D.

M. D. or other

Address: Frostburg Md Date signed 12-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10761

Reg. Dist. No. 4

DR. W. F. WILLIAMS

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 DAYS

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: WEST VIRGINIA County: MORGAN

City or town: PAW PAW
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

PARKER, FRANK F. MR.

3. (b) Social Security Number

232-10-2539

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: ANNA BOWLEY

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): MARCH 17, 1877

8. AGE: Years	Months	Days	If less than one day
70	9	7	...hrs. ...min.

9. Birthplace: WEST VIRGINIA
(Town, county, and state)

10. Usual occupation: KEYSTONE TANNING & GLUE CO.

11. Industry or business: Tannery

FATHER
12. Name: Frank Foster Parker
13. Birthplace: Greenspring, W. Va.

MOTHER
14. Maiden name: Margaret McBride
15. Birthplace: Greenspring, W. Va.

16. Informant: Mrs Anna Bowley Parker
Address: Paw Paw, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/28/47 (month) (day) (year)
Cemetery or crematory: Camp Hill Cemetery
Location: Paw Paw, W. Va.

18. Funeral director: William Parks,
Address: Berkley Springs, W. Va.

19. Dec 26 1947 (Date rec'd by registrar) Hunter R. Scott, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 24 1947, at 4:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-21-1947 to 12-24-1947 and that I last saw him alive on 12-23-1947

Immediate cause of death	DURATION
Bronchogenic carcinoma, returning.	
Due to metastases to brain - kidneys	
Due to and liver.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: See "Cause of death"

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 12/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

178 X

10762

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town 12 Laing Ave Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 2 years.

Hospital, institution, or street address where death occurred:
12 Laing Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Laing Ave
(If rural, give LOCATION)

2.(a) If veteran, name war War 11

3.(a) FULL NAME William Max Phillips

3.(b) Social Security Number 236-14-9636

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22-1914

8. AGE: Years	Months	Days	If less than one day
33	5	10	hrs. min.

9. Birthplace Tunnelton W.Va.
(Town, county, and state)

10. Usual occupation B & O. Fireman

11. Industry or business Railroad

FATHER
12. Name Joseph Warren Phillips
13. Birthplace Rural) Tunnelton W.Va.

MOTHER
14. Maiden name Margaret Rebecca Hooton
15. Birthplace Rowlesburg W.Va.

16. Informant Joseph Carleton Phillips

Address Morgantown W.Va.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 5, 1947 (month) (day) (year)

Cemetery or crematory ***Campground

Location near Tunnelton W.Va.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Dec. 3 1947 (Date rec'd by registrar) W.R. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1947 at about 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive Dead Dec. 2 1947

Immediate cause of death Methane Gas Poisoning — DURATION: about 1 or 2 hours

Due to Open gas stove going to high & no ventilation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Dec. 2-47

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.v. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 12-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 T 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

127a

10763

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 16 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 244 N. Mechanic St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Susan Bessie Plummer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Walter L. Plummer
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Aug. 12 - 1842

8. AGE: Years 55 | Months 4 | Days 14 | If less than one day: hrs. min.

9. Birthplace: Chattanooga Tenn. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Mace Porter
13. Birthplace: Chattanooga Tenn

MOTHER
14. Maiden name: Frances Rutherford
15. Birthplace: Chattanooga Tenn

16. Informant: Mrs. Walter L. Plummer
Address: 244 N. Mechanic St. Frostburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-27-1947 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.

18. Funeral director: Jacob Kaufman
Address: Frostburg, Md.

19. 12-26 1947 Mary Hailey N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 1947 at 7 25/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1942 to Dec 24 1947 and that I last saw h... alive on December 23 1947

Immediate cause of death: Acute Cholecystitis — DURATION: 72 hrs
Due to:
Due to:
Other conditions: Intermittent cerebral arteriospasm — 2 yrs
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jane Walters MD
M. D. or other
Address: Frostburg Md Date signed: 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 c

10764

CERTIFICATE OF DEATH

Reg. Diat. No. D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Highway) near Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? at once

Hospital, Institution, or street address where death occurred:
Route 220 near Rainbow Inn

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Raymond Thomas Potter

3.(b) Social Security Number: 213-12-7362

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Evelyn Metz Potter

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): Aug. 13-1919

8. AGE: Years	Months	Days	If less than one day
28	3	20	...hrs. ...min.

9. Birthplace: Knoxville, Maryland
(Town, county, and state)

10. Usual occupation: Naval Supply Depot

11. Industry or business: Mechanicsburg, Pa.

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Viola Potter
15. Birthplace: Maryland

16. Informant: Mrs. Viola Potter
Address: Knoxville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 6 1947 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Dec. 5, 19 47 (Date rec'd by registrar) W. L. Trimble Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3 19 47 at 8.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive Dead Dec. 3 19 47

Immediate cause of death	DURATION
Fractured 3rd cervical vertebrae & fracture of both legs	at once
Due to Hit by an Automobile while walking along highway	
Due to	
Other conditions 2 lacerations of scalp	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident (1/26/48 abby) Date of injury 12-3-47

Where did injury occur? near Cresaptown (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) highway Route 220

Means of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed 12-3-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

DR. WHITWORTH

10765

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: WEST VIRGINIA County: MINERAL

City or town: RT. # 1, RIDGELEY, WEST. VIRGINIA
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ~~BABY GIRL~~ Joyce Lynn POWNALL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DECEMBER 13, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hrs. min.

9. Birthplace ALLEGANY, CUMBERLAND MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name MR. DICK POWNALL
13. Birthplace WEST VIRGINIA, Greenland

MOTHER
14. Maiden name MARJORIE AMBROSE
15. Birthplace WEST VIRGINIA Hamilton

16. Informant Memorial Hosp.
Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 15 1947 (month) (day) (year)

Cemetery or crematory Hendricks

Location Hendricks, W.Va.

18. Funeral director W. H. Rogers

Address Keyser, W.Va.

19. Dec. 15 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 14 1947 at 1:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Dec 1947 to 14 Dec 1947 and that I last saw h... alive on 14 Dec 1947

Immediate cause of death	DURATION
Prematurity	
Due to Undetermined	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Fuller S Whitworth M. D. or other

Address 112 Bedford St. Date signed 14 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157e

10766

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Midland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ~

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No. ~

(If rural, give LOCATION)

2.(a) If veteran, name war ~

3.(a) FULL NAME Margaret Jean Ravenscroft

3.(b) Social Security Number ~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child

6.(b) Name of husband or wife ~

6.(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1947

8. AGE: Years	Months	Days	If less than one day
	1	3	...hrs. ...min.

9. Birthplace Frostburg Allegany Co. Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name Wilson Ravenscroft

13. Birthplace Maryland

MOTHER

14. Maiden name Anna Belle McKinley

15. Birthplace Scotland

16. Informant Wilson Ravenscroft

Address Midland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 25, 1947 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md

18. Funeral director M. Eichelson

Address Lonaconing, Md

19. Dec 30 1947 (Date rec'd by registrar) Jeannette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24th 1947, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~ 19... to ~ 19...

and that I last saw h... alive on ~ 19...

Immediate cause of death	DURATION
Died not well developed, until shortly after death	
Heart deficiency, congenital	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Henry M. Hodgson M.D. M. D. or other

Address R.1 Box 132 Cumberland, Md Date signed Dec. 29 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10767

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Michael Clement Reagan

3.(b) Social Security Number: 217-07-7871

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lena Reagan

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): June 3, 1898

8. AGE: Years 49 Months 6 Days 22 If less than one day ____ hrs. ____ min.

9. Birthplace: Mt. Savage Allegany Md. (Town, county, and state)

10. Usual occupation: machinist helper

11. Industry or business: Celanese plant

FATHER 12. Name: Michael Reagan

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Sarah Malloy

MOTHER 15. Birthplace: Mt. Savage Md

16. Informant: Mrs. Bertha Worrell

Address: Mt. Savage Md.

17. Burial, (Burial, cremation, or removal. Which?) Date thereof: Dec 29 1947 (month) (day) (year)

Cemetery or crematory: St. Patricks

Location: Mt. Savage Md

16. Funeral director: J. R. Obrist

Address: Frostburg Md.

19. Dec 27- 1947 (Date rec'd by registrar) Vernie M. Dennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25th 1947 at 9:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 1947, to Dec. 25th 1947 and that I last saw him alive on December 25th 1947

Immediate cause of death	DURATION
Coronary Occlusion.	9 minutes
Due to	
Due to	
Other conditions: Moderate Vascular Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William E. Moseley M. D.

M. D. or other

Address: Mt Savage Md. Date signed: 12/26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr M.E.B Owens.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10768

Reg. Dist. No. 1

1. PLACE OF DEATH:

County: Allegany

City or town: Oldtown, R.D.1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Oldtown R.D. 1
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Oldtown, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Martha Jane Reckley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1945

8. AGE:

Years	Months	Days	If less than one day
2	10	6	..... hrs. ..... min.

9. Birthplace: Picardy, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Joseph Reckley
13. Birthplace: Welch, W.Va.

MOTHER
14. Maiden name: Helen Puffenberger
15. Birthplace: Town Creek, Maryland

16. Informant: Joseph Reckley
Address: Oldtown, R.D.1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18, 47 (month) (day) (year)

Cemetery or crematory: Reckley Cemetery

Location: Kifer, Maryland

18. Funeral director: Charles L George

Address: 202 Greene Street

19. Dec 17 19 47 (Date rec'd by registrar) C.C. Bauhalt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 19 47, at 2.55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 19 47, to Dec 16 19 47

and that I last saw h.. alive on Dec 13 19 47

Immediate cause of death	DURATION
Bronchopneumonia	4 dy
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Max Owens M. D. or other

Address: 133 Van Date signed: 12/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

10769

Reg. Dist. No. 4

CERTIFICATE OF DEATH

W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

VS A15. 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

472 Goethe St.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 472 Goethe St.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: IDA MAY RICE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Theodore Rice

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 2, 1859

8. AGE: Years	Months	Days	If less than one day
88	5	28	..... hrs. ..... min.

9. Birthplace: Cumberland Valley, Pennsylvania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Nelson Paxton

13. Birthplace: Cumb. Valley, Pennsylvania

MOTHER — 14. Maiden name: Susanne Rice

15. Birthplace: Cumb. Valley, Pennsylvania

16. Informant: Miss Goldie Rice

Address: 472 Goethe St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 3, 1948 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Jan 2 1948 Carl Frantz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31, 1947, at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1943 to Dec. 31 1947 and that I last saw h[er] alive on Dec. 30 1947

Immediate cause of death	DURATION
Cardiac failure	
Due to: rectal cancer	3 yrs.
Due to:	
Other conditions: old age	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Brown M.D. M. D. or other

Address: La Vale, Md. Date signed: 1/3/48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

78d

10779

Reg. Dist. No. 4

Dec 1 1947

1. PLACE OF DEATH: ~~Dec 1 1947~~

County Allegany Cumberland Md

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~At Home~~

Hospital, Institution, or street address where death occurred

843 Lephart Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 843 Lephart Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah. Ella. Richards

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Thomas Davis Richards

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1856

8. AGE: Years 91 Months 5 Days 8 If less than one day hrs. min.

~~91 June 23 1856~~

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name William Carl

13. Birthplace Pa

MOTHER 14. Maiden name Anna Gregory

15. Birthplace Pa

16. Informant Carl Richards

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4 1947 (month) (day) (year)

Presbyterian Cemetery Warfordsburg Pa

Cemetery or crematory

Location Near Hancock Md

18. Funeral director John E Wolford

Address Cumberland Md

19. Dec 3 1945 W. R. Frantz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/47 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/1/47 19 to 12/1/47 19

and that I last saw h[illegible] alive on 12/1/47 19

	DURATION
Immediate cause of death Chr Myocarditis	
Due to Arteriosclerosis of age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. J. Williams M.D. M. D. or other

Address Md Date signed 12/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

10771

Reg. Diat. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: ~~Cumberland~~ Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 82 Yrs 8 Mo 2 Days

Hospital, Institution, or street address where death occurred:

Rural Flintstone, Md.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Thomas Robosson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Robosson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3 1865

8. AGE: Years	Months	Days	If less than one day
82	8	2	..... hrs. ..... min.

9. Birthplace: Flintstone, Allegany Co, Maryland

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER

12. Name: Thomas Robosson

13. Birthplace: Flintstone, Md.

MOTHER

14. Maiden name: Mary Bell

15. Birthplace: Belle Grove, Md.

16. Informant: Charles T. Robosson, Jr.

Address: Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/7/47 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec. 6. 1947 (Date rec'd by registrar) Nina L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1947, at 5-40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1, 1947, to Dec 5 1947

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Gangrene of foot	25 days
Due to: Arteriosclerosis	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: R. W. Trewachis M.D. or other

Address: Cumberland, Md Date signed: Dec 6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

10772

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 DAYS
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITTL
How long in hospital or institution? 20 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND, Mexxxxal
(If outside city or town limits, write RURAL and give nearest town)
Street No. RT. # 3
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American War

3.(a) FULL NAME ROLLINS, WILLIAM I. MR.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife ROWE, NELLIE
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 27 1865

8. AGE: Years	Months	Days	If less than one day
82	10	24	..... hrs. ..... min.

9. Birthplace Augusta, Georgia
(Town, county, and state)
10. Usual occupation RETIRED
11. Industry or business —

FATHER
12. Name ROLLINS, Unknown
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant Mrs Vera Borgman
Address Rt # 3 Cumberland

17. Burial (Burial, cremation, or removal? Which?) Date thereof Dec 20 47 (month) (day) (year)
Cemetery or crematory St Marys Cem
Location Cumberland, Md
18. Funeral director Louis Stein Inc
Address Cumberland

19. 12-19-47 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 16, 1947 19..... at 9:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 19 47 to Dec 16 19 47
and that I last saw h.. alive on Dec 16 19 47

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to Arteriosclerosis	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results NO
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. L. Emerson M.D. M. D. or other
Address 26 Queen St Cumberland Md Date signed 12/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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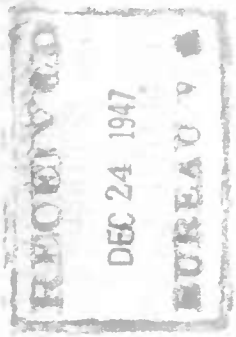
(Have been cited)



Within corporate limits

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Fr. 10773

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL Hospital

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town OAKLAND,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 62 SECOND ST.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME

ROOT, ~~BABY GIRL~~ Barbara Helen

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DEC. 6, 1947

8. AGE: Years	Months	Days	If less than one day
		2	hrs. ~~Allegany County~~ min.

9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name ROBERT ROOT
13. Birthplace W.VA.

MOTHER
14. Maiden name HELEN SHOBE,
15. Birthplace W.VA.

16. Informant Mr. Robert Root
Address 62 Second St., Oakland, Md.

17. Burial Date thereof Dec. 9 1947
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Oakland Cem

Location Oakland, Md.

18. Funeral director Robert Root - Father
Address Oakland Md.

19. Dec 8, 1947 Wm. L. Lantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 8 1947 at 10:41 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1947 to Dec 8 1947

and that I last saw h[illegible] alive on Dec 8 1947

	DURATION
Immediate cause of death Premature Infant	
Due to Premature Labor	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Julius B. Kuhn M. D. or other

Address 112 Bedford Date signed Dec 8

W

I

H

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10774

DR. W. F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL, CUMBERLAND, MD.
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 613 WILLIAMS ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SHAW, SELVY MR.

3.(b) Social Security Number: 705-07-9504

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: ANNIE PRICE
8.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): SEPTEMBER 4, 1876

8. AGE:

Years	Months	Days	If less than one day
71	3	20	...hrs. ...min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: ~~B & O~~ (RETIRED) - Crossing Watchman
11. Industry or business: B. and O. R.R. Co.

FATHER
12. Name: SHAW, ISAAC
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: RICE, MARY
15. Birthplace: MARYLAND

16. Informant: Mrs. Annie Price Shaw
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27 47 (month) (day) (year)
Cemetery or crematory: St Marys Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland

19. Dec 26 1947 (Date rec'd by registrar) Wade A Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 24 1947 at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-23-1947 to 12-24-1947 and that I last saw him alive on 12-23-1947

Immediate cause of death	DURATION
Cerebral Hemorrhage.	16 hrs.
Due to: Malignant Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.: none

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Insure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr P.E. Berry. 93d

Reg. Dist. No. 10775 6

1. PLACE OF DEATH:

County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, Institution, or street address where death occurred: Fairview St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fairview

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sarah Tabitha Shipe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Isaac Shipe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 18, 1861

8. AGE: Years: 86 | Months: 3 | Days: 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pregittsville Hardy, W. Va.

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own Home

FATHER

12. Name: Henry Sulser

13. Birthplace: W. Va

MOTHER

14. Maiden name: Mary High

15. Birthplace: W. Va.

16. Informant: Mrs Nellie Wolfe

Address: Luke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9, 1947 (month) (day) (year)

Cemetery or crematory: Queens Point Cemetery

Location: Keyser, W. Va.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Dec 8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7 19 47 at 12:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 44, to December 19 47 and that I last saw her alive on December 7 19 47

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE P.E. Berry, M.D. M. D. or other

Address: Piedmont, W. Va. Date signed Dec -8-1947

W

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 10776

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMROIAL HOSPITAL,

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 WEBER ST.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME CHARLES M. SHRYOCK

3.(b) Social Security Number 196-09-2498

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARYLAND MOWER

6.(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) APRIL 1, 1901

8. AGE: Years	Months	Days	If less than one day
46	8	30	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business Enterprise Amusement Co.

FATHER
12. Name ALFRED SHRYOCK
13. Birthplace MD

MOTHER
14. Maiden name GENEVA ATHEY
15. Birthplace MD

16. Informant Mrs. Marilyn Shryock
Address 29 Weber St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3, 1947 (month) (day) (year)

Cemetery or crematory Shryock Family Cem.

Location Town Creek, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Dec. 3, 1947 (Date rec'd by registrar) W. K. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 1 1947 at 2:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 28 1947 to Dec 1 1947 and that I last saw him alive on Dec 1 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John N. Rozum M.D. M. D. or other

Address Cumberland Md Date signed 12/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10777

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65-6-17
Hospital, institution, or street address where death occurred:
81 N. Centre St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 81 N Centre St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ralph B. Shuck
3.(b) Social Security Number 149-05-7215

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Lillian Walters Talley
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) May 15 1882
8. AGE: Years 65 Months 6 Days 17 If less than one day ... hrs. ... min.
9. Birthplace Cumberland Md (Town, county, and state)
10. Usual occupation Machinist
11. Industry or business Telephone
FATHER 12. Name John Shuck
13. Birthplace Cumberland Md
MOTHER 14. Maiden name Susan Conner
15. Birthplace Cumberland Md
16. Informant Wm T. Shuck
Address Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 6 47 (month) (day) (year)
Cemetery or crematory Rose Hill Cem
Location Cumberland Md
18. Funeral director Louis Stein Inc
Address Cumberland, Md.
19. Dec. 5 1947 (Date rec'd by registrar) Hunter R. Trout M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1947 at 7 00 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 19 1947, to Dec 3 1947
and that I last saw h... alive on Nov 28 1947

	DURATION
Immediate cause of death Coronary Thrombosis	
Due to Coronary Sclerosis	four months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lloyd T. Lee Jr M.D. M. D. or other
Address 40 4 Decatur St Date signed 12-4-47

MARGIN RESERVED FOR BINDING

Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

926

Reg. Dist. No. 14 — 10778

1. PLACE OF DEATH:
County: Allegheny
City or town: Ellerslie (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegheny
City or town: Ellerslie (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Dorothy Louise Smith
3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): January 13, 1931
8. AGE: Years 16, Months 10, Days 22. If less than one day ... hrs. ... min.
9. Birthplace: Ellerslie, Allegheny Co., Md. (Town, county, and state)
10. Usual occupation: Student
11. Industry or business:
FATHER 12. Name: Sherman Smith
13. Birthplace: " " Pa.
MOTHER 14. Maiden name: Virgie Emerick
15. Birthplace: Pa.
16. Informant: Sherman Smith
Address: Ellerslie, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1947 (month) (day) (year)
Cemetery or crematory: Madley
Location: Londonderry Twp., Bedford Co., Pa.
18. Funeral director: H. H. Leighty
Address: Hyndman, Pa.
19. Dec 9 1947 (Date rec'd by registrar) J. Lloyd Wolfe, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5, 1947, at ... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1, 1945, to Dec 5, 1947; and that I last saw her alive on Dec 5, 1947

Immediate cause of death	DURATION
Mitral Insufficiency	
Due to Rheumatic	5 yrs
Due to Heart Disease	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 404 Decatur St. Date signed: 12/7/47

F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47a

Reg. Diat. No. 10779

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rodney Kelsall Smith

3.(b) Social Security Number 214-07-0180

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Lulu Barnett Smith

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) January 2, 1886

8. AGE:

Years	Months	Days	If less than one day
61	11	15	..... hrs. ..... min.

9. Birthplace Wellsburg, W. Va.

(Town, county, and state)

10. Usual occupation Stat. Engineer

11. Industry or business K-S Tire Co.

FATHER 12. Name Gerrit Smith

13. Birthplace Unknown

MOTHER 14. Maiden name Mary Caldwell

15. Birthplace Unknown

16. Informant Mrs. Lulu Smith

Address Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 20, 1947 (month) (day) (year)

Cemetery or crematory Everett Cemetery

Location Everett, Pa.

18. Funeral director John J. Hofer

Address Cumberland

19. Dec. 18, 1947 (Date rec'd by registrar) J. Floyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1947 at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-14-1947 to 12-19-1947 and that I last saw h... alive on 12-17-1947

Immediate cause of death	DURATION
Carcinoma of Larynx.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma Date of op. 4 years ago

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 12/19/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10784

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
421 Homer St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 Homer St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ruth Jeanette Stafford

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 21, 1943

8. AGE:

Years	Months	Days	If less than one day
4	10	11	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER
12. Name: John M. Stafford
13. Birthplace: Cumberland

MOTHER
14. Maiden name: Norma Zinn
15. Birthplace: Meyersdale, Pa.

16. Informant: Mrs. Norma Zinn Stafford
Address: 421 Homer St. Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 3, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Hermon Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md

19. Dec 3, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 19 47 at 7: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30. 19 47, to Dec. 2. 19 47
and that I last saw h[illegible] alive on Dec. 1 19 47

Immediate cause of death: Diphtheria — DURATION: 10 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Clay Turner M. D. or other

Address: Cumberland Date signed: 12/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10781

8

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred: 174 Funnace St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 Furnace St. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Anna L. Duckworth-Stark

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Stark

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 13, 1864

8. AGE:

Years	Months	Days	If less than one day
82	8	28	hrs. min.

9. Birthplace: New Germany, Garrett Co., Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER — 12. Name: Hiram Duckworth

FATHER — 13. Birthplace: New Germany Garrett Co, Md

MOTHER — 14. Maiden name: Rebecca Michael

MOTHER — 15. Birthplace: Finn Rock, Md

16. Informant: Alvin Stark

Address: Long Beach, Cal.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 5, 1947 (month) (day) (year)

Cemetery or crematory: New Germany Cemetery

Location: New Germany, Garrett Co., Md.

18. Funeral director: M. E. Dickhaus

Address: Lonaconing, Md.

19. 12/5/47 (Date rec'd by registrar) Jeannette M. Coal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/3/1947 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/27/47 19— to 19— and that I last saw h.e.r alive on 9/27/ 1947

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Hypertension - Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Paul Eugene Dyer, M.D. (M. D. or other)

Address: Lonaconing Md Date signed: 12/4/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10782

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred: 50 Browning St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New Jersey County: Camden

City or town: Audubon

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 216 W. Atlantic Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Samuel Eveland Stull

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife: Hannah Stull

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1873

8. AGE:	Years	Months	Days	If less than one day
	74	10	17	hrs. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Pa. Railroad

FATHER

12. Name: John H. Stull

13. Birthplace: Philadelphia, Pa.

MOTHER

14. Maiden name: Sophia Echaren

15. Birthplace: Alsace Lorraine, France

16. Informant: Mrs. Myrtle Shapley

Address: 50 Browning St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23, 1947 (month) (day) (year)

Cemetery or crematory: K of P Greenwood Cemetery

Location: Philadelphia, Pa.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Dec 22 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1947 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 47 to Dec 19 1947 aed that I last saw h... alive on Dec 19 1947

Immediate cause of death	DURATION
Tuberculosis, pulmonary	7 yrs
Due to	4 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lloyd Flees M.D. M. D. or other

Address: 104 Decatur. Date signed: 12/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits
Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

10783

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, Institution, or street address where death occurred: 415 Race St

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs Anna Virginia Swartley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jerome R. Swartley

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept 12, 1866

8. AGE:

Years	Months	Days	If less than one day
81	2	26	..... hrs. ..... min.

9. Birthplace: Lebanon Indiana
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: Martin Rohrer
13. Birthplace: Md.

MOTHER
14. Maiden name: Alice McArdle
15. Birthplace: Md.

16. Informant: Mrs Robt Bowers
Address: 328 Fayette St - Cumberland Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Dec 11, 1947
(month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 11, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1947, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947, to Dec 5 1947

and that I last saw h[illegible] alive on Dec 5 1947

Immediate cause of death: Cardiac Insufficiency — DURATION: Hours

Due to: Hypertensive Cardio Sclerosis

Due to: Myocardial Fibrosis

Other conditions: Arterio Sclerosis, Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 40 Decatur Date signed: 12/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. ELIASON
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10784

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State [redacted] W. Va. County Preston
City or town [redacted] Terra Alta W Va
(If outside city or town limits, write RURAL and give nearest town)
Street No. EAST STATE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
TASKER, DORIS ANN

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 11, 1947

8. AGE: Years	Months	Days	If less than one day
~~3 MONTHS~~	2	20	..... hrs. ..... min.

9. Birthplace W.VA., Terra Alta, Preston Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name TASKER, DONALD
13. Birthplace W.VA., Terra Alta

MOTHER
14. Maiden name KING, ANNA
15. Birthplace Terra Fairchance

16. Informant Mrs. Donald Tasker
Address Terra Alta, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4 1947 (month) (day) (year)
Cemetery or crematory Oak Grove Cem
Location Terra Alta, W. Va.

18. Funeral director Fike-Watson
Address Terra Alta, W. Va.

19. Dec. 10, 1947 (Date rec'd by registrar) W. A. Trautz, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 1, 1947, at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 1 1947 and that I last saw h[redacted] alive on 12-1 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	1 Wk
Due to Whooping Cough	3 Wks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. O. Eliason M.D. M. D. or other
Address 12-8-47 Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

ALLEGANY COUNTY HEALTH DEPARTMENT
CUMBERLAND, MARYLAND

INTER OFFICE COMMUNICATION

Date Dec. 10, 1947.

To: Dr. A. W. Hedrich

From: Dr. W. R. Frantz

Remarks:

Attached you will find the death certificate of Doris Ann Tasker, who died in Memorial Hospital, on December 1, 1947. This certificate was not received in this office until this morning. It had been mislaid at the office and wasn't signed by the physician in charge until December 8th. This is indirectly the fault of the hospital, the physician and the funeral director, with whom I have just talked. The latter wrote to the hospital this past week and asked why a burial permit had not been received and also enclosed the missing information for the certificate.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13d

10785

CERTIFICATE OF DEATH

Reg. Diat. No. 4

W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 Yrs 10 Mo 2 Days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 6 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 331 Frederick St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Jacob Taylor

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Edith Hollingsworth Taylor

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): February 4 1892

8. AGE: Years	Months	Days	If less than one day
55	10	2	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co, Maryland

(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Cleaning

FATHER 12. Name: Henry Taylor

FATHER 13. Birthplace: Cumberland Md

MOTHER 14. Maiden name: Jane Williams

MOTHER 15. Birthplace: Cumberland Md.

18. Informant: Henry Taylor

Address: 331 Frederick St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec. 8, 1947 (Date rec'd by registrar) W.R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 1947 at 6-30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 6 1947 to December 6 1947 and that I last saw him alive on December 6 1947

	DURATION
Immediate cause of death: Supraventricular Tachycardia	5 hours
Due to: Myocardial Infarction (Posterior wall)	7 hours
Due to: Coronary occlusion Arteriosclerotic Heart Disease ?	7 hours
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Everett G. Weeseman M.D. M. D. or other

Address: 22 Bedford St Cumberland Date signed: 12/7/47

Within corporate lim DR COOPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

10786

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: BOWLING GREEN Pl. #6
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Baby Boy Theis

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 11, 1947

8. AGE: Years | Months | Days | If less than one day: 24 hrs. ____ min.

9. Birthplace: CUMBERLAND, Alleg Co., Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: THEIS, FRED
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: KLOSTERMAN, LOLA
15. Birthplace: MARYLAND

16. Informant: Frederick W. Theis
Address: Bowling Green, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1947 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Dec. 13, 1947 (Date rec'd by registrar) W. H. Fraunfelter, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 12, 1947, at 1:00PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12 Dec. 1947 to 12 Dec. 1947

and that I last saw h.i. alive on 12 Dec 47

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: L. A. Cooper M.D. M. D. or other

Address: 132 S. Centre St. Date signed: 13 Dec 47

DR COOPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

10787 for Insurance

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel J. Thomas

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife: Mary E. Thomas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 17 - 1866

8. AGE:

Years	Months	Days	If less than one day
81	2	8	..... hrs. ..... min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Service Station operator

FATHER 12. Name: Henry Thomas

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace

16. Informant: Mrs Dora Ravenscroft

Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 28-1947 (month) (day) (year)

Cemetery or ~~cemetery~~: allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Dubel

Address: Frostburg, Md.

19. 12-28 1947 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1947 at 10 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Dec 25 1947 and that I last saw him alive on Dec 24 1947

Immediate cause of death	DURATION
Chr Myocarditis	several years
Due to: Diabetes	yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W D McLane MD (M. D. or other)

Address: Frostburg Md Date signed: Dec 27 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10788

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, Institution, or street address where death occurred: 101 West Main Street

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 101 W. Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Elizabeth McDonaldson Turnbull

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: David Turnbull

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Mar. 24, 1874

8. AGE:

Years	Months	Days	If less than one day
73	8	23	... hrs. ... min.

9. Birthplace: Berkshire, Scotland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: William Donaldson
13. Birthplace: Scotland

MOTHER
14. Maiden name: Catherine Brown
15. Birthplace: Scotland

16. Informant: Wm. Turnbull
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 9 1947 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Dec. 19 1947 (Date rec'd by registrar) Jeannette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/17/1947 at 2 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/17/1947 to 12/17/1947 and that I last saw h.e. alive on 12/17/1947

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to: Arteriosclerosis Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Eugene Frye, M.D.
M. D. or other

Address: Lonaconing, Md. Date signed 12/19/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits Elec

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 838

CERTIFICATE OF DEATH

10789

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
212 Thomas St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 212 Thomas St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Frank Violante

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 6 1944

8. AGE:

Years	Months	Days	If less than one day
3	11	14	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Dominic Violante
13. Birthplace: Italy

MOTHER
14. Maiden name: Mary Frammartino
15. Birthplace: Boston, Mass.

16. Informant: Dominic Violante

Address: 212 Thomas St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23, 1947 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: 202 Greene St.

19. Dec 22 1947 (Date rec'd by registrar) H.K. Beachy, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20, 1947 at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12.20 1947 to 12.20 1947

and that I last saw him alive on 12-20 1947

Immediate cause of death: Cerebral Poraplegia — DURATION: 3 yrs

Infantile

Due to: Infantile Sporke — 3 yrs

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: N. W. Alexander M. D. or other

Address: 26 Mercer St. Cumberland — Date signed: 12/22/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

10790

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:
128 Springdale, St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 Springdale, St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lillie Warner

3.(b) Social Security Number None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Walter Warner

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1879

8. AGE:

Years	Months	Days	If less than one day
68	10	18	..... hrs. ..... min.

9. Birthplace Murley Branch Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Cambridge Wilson

13. Birthplace Md

MOTHER 14. Maiden name June Browning

15. Birthplace Md

16. Informant Earl Warner

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/22/1947 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md

19. Dec. 26 1947 Walter R. Trout, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1947 to Dec. 25 1947

and that I last saw him alive on 1947

Immediate cause of death	Diabetes Mellitus	DURATION 8 yrs.
Due to	Arteriosclerosis	7 yrs.
Due to	Nephritis	1 yr.
Other conditions	Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Adams M.D.
M. D. or other

Address 133 Va Ave Date signed 12-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

CERTIFICATE OF DEATH

10791

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47-5-25
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 126 New Hampshire Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Lawrence Weber
3. (b) Social Security Number 214-05-6383

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Alice Patton Weber
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 18 1900
8. AGE: Years 47 Months 5 Days 25 If less than one day ..... hrs. ..... min.
9. Birthplace Cumberland Md (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Grocery Store
FATHER 12. Name Joseph M. Weber
13. Birthplace Cumberland Md
MOTHER 14. Maiden name Anna Lesch
15. Birthplace Germany
16. Informant Mrs Jos. L. Weber
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 16 47 (month) (day) (year)
Cemetery or crematory St Marys Burial Park
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland
19 Dec 15, 1947 (Date rec'd by registrar) W. H. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1947, at 10:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-8-1947, to 12-12-1947
and that I last saw h... alive on 12-13-1947

Immediate cause of death Biliary Cirrhosis — DURATION
Appendical Abscess
Due to
Other conditions One yr. ago Rt. Infectious Jaundice 3 mos
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M.D. or other
Address Cumberland Date signed 12/15/47

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Fred Williams

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10792

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Hell Gap Drive 4 yrs

Hospital, Institution, or street address where death occurred: Hell Gap Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: West Virginia County: Otsego

City or town: Perry (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Emma Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William H. Wilson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 19, 1866

8. AGE: Years: 81 Months: 3 Days: 10 If less than one day: hrs. min.

9. Birthplace: McCauley W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER

12. Name: Levi Baughman

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Elizabeth Bird

15. Birthplace: W. Va.

16. Informant: Mrs. Elizabeth Snyder

Address: Perry W Va

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan 1, 1948 (month) (day) (year)

Cemetery or crematory: Mt Maria

Location: Perry, W. Va.

18. Funeral director: Ellsworth Bros

Address: Westernport. Md

19. Dec 30 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 29 19 47 at 5:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 19 47, to Dec 29 19 47

and that I last saw h w alive on Dec 27 19 47

Immediate cause of death	DURATION
Carcinoma of breast with metastasis to lungs	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Norman Reece, M. D. M. D. or other

Address: Westernport, Md Date signed: Dec 30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING